Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GREATER HOURSTON EMERGENCY PHYSICIANS
PO BOX 20047
HOUSTON TX 77216-0475

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-0326-01

MFDR Date Received
OCTOBER 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was billed to Texas Mutual on 02/09/2012 and denied on 03/21/2012. Denial Reason was Documentation and file review does not support an emergency in accordance with rule 133.2. I resubmitted Medical Records because they indicate the patient was seen for chronic back pain."

Amount in Dispute: $421.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant went to the emergency department at Northeast Methodist Hospital on the date above. He admitted himself Tuesday, 1/24/12, at 1:35pm reporting low back pain. An x-ray to the low back was taken. The ER doctor noted moderate pain to low back with muscle spasm, and prescribed an injection. The claimant was discharged at 3:35pm. The claimant had been receiving treatment from his treating doctor since 12.5.11…There is no indication or evidence the claimant attempted to contact his treating doctor prior to showing up at the ER. The documentation does not meet the definition of an emergency at Rule 133.2. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2012	CPT Code 99284	$421.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2, titled *Definitions*, effective July 27, 2008, 33 TexReg 5701, defines words and terms.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC-W1-Workers compensation state fee schedule adjustment.

- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 899-Documentation and file review does not support an emergency in accordance with rule 133.2.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.
- CAC-18-Duplicate claim/service.
- 736-Duplicate appeal. Network contract applied by Texas Star Network.

Issues

1. Does the documentation support the disputed services were for a medical emergency? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.2(3) states "Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part."

   CPT code 99284 is defined as "Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function."

   Review of the submitted Emergency Physician Record report indicates that the claimant sought treatment for back pain that began two days before. The report indicates that the claimant appeared in no acute distress. The physical exam findings were negative except for muscle spasms. X-ray studies findings were normal. Claimant was discharged home two hours later in stable condition. The documentation does not support a medical emergency as defined by 28 Texas Administrative Code §133.2(3)(A)(i)(ii). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	9/24/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.